The Eye Clinic

Dr Simon Irvine theeyeclinic.au

Level 1 694 Pittwater Rd
BROOKVALE 2100

Ph: 9981 2033
Fax: 9981 3033

Dear Dr. .....,

PLEASE PRINT COMPLETED FORM AND GIVE TO PATIENT

Patient Details

Name: .....

Phone: ..... Date of Birth: .....

BCVA ..... R..... PH ..... L ..... PH .....

Refraction ..... R..... L .....

Reason

- ☐ Cataract
- ☐ Diabetic eye disease
- ☐ Glaucoma
- ☐ Flashes & floaters
- ☐ Retinal detachment
- ☐ Watery eye
- ☐ Eye Pain
- ☐ Other

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Referrer's Details

Name: ..... **Provider Number :.....**

Address: .....

Email: .....

Phone: ..... Fax: .....

Signature: ..... Date:.....

PLEASE BRING:

Referral, Medicare Card, Pension card, glasses, sunglasses, list of medications, health fund details.

As your pupils will be dilated and your vision will be blurry for 2 – 4 hours driving is not recommended. Bring sunglasses.

If you have difficulty with drop off, please call on arrival and someone will come to assist you.